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Module name: Independent Project

Module code:BMHP6020

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Exploring the Causes and Impact of Medication Errors in Health and Social Care Settings

Introduction:

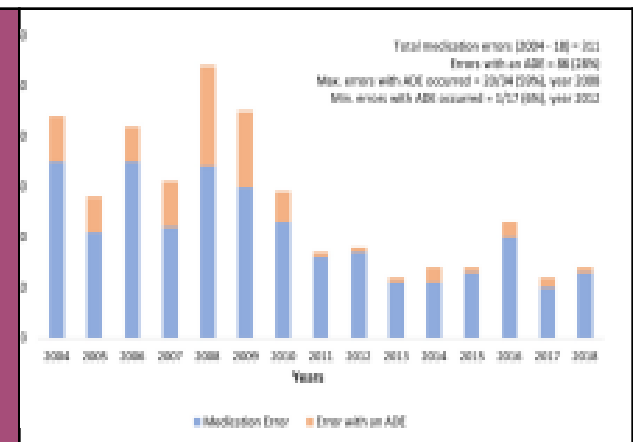
Medication errors are a major concern in health and social care settings, as

Aim:

The aim of this project is to investigate the causes of medication errors in health and social care settings and to explore their impact on service users, staff, and care organisations.

Objectives:

- To identify the main causes of medication errors in health and social care settings.
- To explore how medication errors affect service users' health, safety, wellbeing and



(Abbasi, Rashid and Khan, 2022)

Data Analysis method:

- This project will use thematic

they can affect patient safety, health and wellbeing. These errors can occur during prescribing, dispensing, administering or monitoring medication. Common causes include poor communication, inadequate staff training, heavy workloads, staff shortages and incorrect documentation. Medication errors can lead to patient harm, increased healthcare costs and reduced trust in care services. This project will explore the main causes and impacts of medication errors and identify ways to improve medication safety and the quality of care.



Methodology:

- This project will use a secondary research method to explore the causes and impact of medication errors.
- Reliable sources will include

trust.

- To examine the impact on professionals, including stress, accountability and responsibility.
- Recommend improving communication, training, staffing, and documentation to reduce medication errors.



Ethical considerations:

Ethical Approval: Not required, as this project uses publicly available secondary research and does not involve human participants.

Confidentiality: Respecting patient privacy and ensuring no personal or identifiable information is disclosed.

Academic Integrity: Avoiding plagiarism by acknowledging all sources and using accurate Harvard referencing.

Data Collection: Using reliable and trustworthy sources, including NHS

analysis to identify common causes and impacts of medication errors.

- Secondary data will be collected from NHS reports, CQC publications and academic journals.
- Findings will be grouped into themes such as poor communication, staff shortages, inadequate training and documentation errors.
- The findings will be compared to identify patterns and risks affecting patient safety.
- The results will help recommend improvements to medication safety (Elliott et al., 2021).



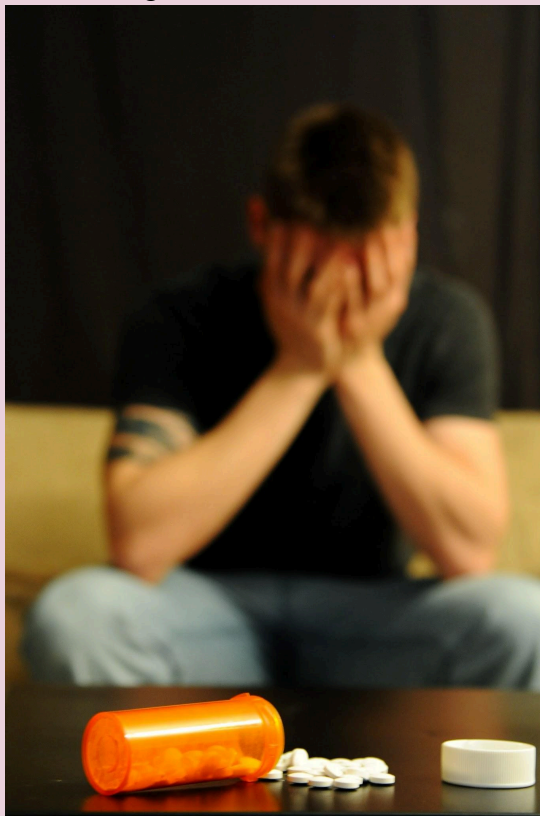
Data collection:

Databases: Searching PubMed, CINAHL and ProQuest for relevant academic studies.

Research Focus: Exploring workplace stress and staff shortages in UK healthcare settings.

NHS guidance, CQC publications, government reports, books, journals and patient safety resources.

- Sources from 2017 to 2026 will ensure the information is current.
- Keywords include communication, training, staffing, documentation and organisational weaknesses.



reports, CQC publications and peer-reviewed journals.

Accuracy: Presenting research findings honestly without changing or misrepresenting information.

Bias: Recognising potential bias in published studies and ensuring a balanced interpretation of findings.

Transparency: Clearly explaining the research methods, findings and limitations.

Responsible Research: Following ethical academic principles to ensure the research is credible, respectful and trustworthy (Fromm, 2025).



Keywords: Using terms such as “workplace stress”, “staff shortages”, “healthcare workers”, “NHS” and “UK healthcare”.

Search Techniques: Using Boolean operators (AND, OR) to improve search accuracy.

Inclusion Criteria: Selecting relevant peer-reviewed studies published between 2019 and 2026.

Exclusion Criteria: Excluding outdated, irrelevant and unreliable publications.

Study Selection: Reviewing titles, abstracts and full texts to identify suitable research.

Evidence Quality: Assessing the reliability, relevance and limitations of selected studies (Shehata, 2025).





References

Care Quality Commission (CQC) (2022) Reporting medicine related incidents. Available at: <https://www.cqc.org.uk/guidance-regulation/adult-social-care/medicines-information-adult-social-care-services/reporting-medicine-related-incidents> (Accessed: 15 June 2026).

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Elliott, R.A., Camacho, E., Jankovic, D., Sculpher, M.J. and Faria, R. (2021) 'Economic analysis of the prevalence and clinical and economic burden of medication error in England', *BMJ Quality & Safety*, 30(2), pp. 96–105. Available at: <https://qualitysafety.bmj.com/content/30/2/96> (Accessed: 30 October 2026).

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